

CITY OF MINNEAPOLIS, REGULATORY SERVICES INSPECTIONS DIVISION 250 South 4th Street – Room 300 Minneapolis, MN 55415-1316

www.ci.minneapolis.mn.us/mdr

BACKFLOW PREVENTOR (RPZ) TEST REPORT

JOB ADDRESS:								
OWNER/OCCUPANT/CONTACT PERSON:					CONTACT PHONE:			
				1				
DEVI	ICE LOCATION:			FLOOR #:	OOR #:		ROOM #:	
SERVES WHAT SYSTEM:								
MAKE:		MODEL #:	s	SIZE:	E: SERIA		RIAL #:	
INSTALL DATE (MONTH/DAY/YEAR):		OVERHAUL DATE (MONTH/DAY/YEAR): (DO NOT PUT A FUTURE DATE IN THIS BOX)		: BOX)	TEST DATE (MONTH/DAY/YEAR):		:	
		#1 CHECK VALVE PSI/DIFF		RELIEF PSI/DIFF			#2 CHECK VALVE	
	TEST BEFORE REPAIRS							
	FINAL TEST							
DESCRIBE REPAIR IF ANY (IF THIS IS A NEW INSTALLATION AND REPLACES AN EXISTING DEVICE, INDICATE THE SERIAL NUMBER OF THE DEVICE REMOVED):								
TEST DONE BY (PLEASE PRINT FIRST & LAST NAME):				CERTIFIC	CERTIFICATION NUMBER:			
COMPANY NAME:					MPLS CONTRACTOR LICENSE #:			
COMPANY ADDRESS:				СОМР	COMPANY PHONE #:			
CITY: STATE: ZIP:					CONTACT PERSON/PHONE#:			

ATTACH THIS COMPLETED TEST REPORT TO PLUMBING/GASFITTING/RPZ PERMIT APPLICATION AND SUBMIT WITH FEE